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ABSTRACT

This paper describes a model in which parents were taught to modify the behavior of their children. Parents were referred to the group after only brief screening consisting of a lengthy questionnaire, an intake interview with a clinician at a mental health center, and perhaps a brief discussion of the case at a disposition conference. Referrals to the program were made for those parents who indicated that their children manifested behavior problems. Thus, the group tested the adequacy of this model for outpatient treatment of children at a mental health center. Ten couples and one single parent agreed to participate in the course which was for ten two-hour sessions, and met once each week in the evening. The results of the course suggest that academically-oriented courses in behavior management are not sufficient treatment for a large percentage of family cases referred to psychiatric treatment facilities, although they may be adequate for other parent populations such as public school parents. The results further suggest that a more clinical group treatment approach should be considered. The fact that 77% of the group participants did carry out successful programs and that the parents did tend to learn the principles of behavior modification suggests that formal parent behavior modification courses can be the major treatment offered for certain selected clients, and can be of considerable adjunctive value with others. (Author/WSK)

PARENT GROUPS IN BEHAVIOR MODIFICATION: TRAINING OR THERAPY[1]

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INTRODUCTION

Teaching parents to modify the behavior of their children has become a widely used behavioral method (Berkowitz and Graziano, 1972). Walder and his associates (Walder, Breiter, Cohen, Daston, Forbes and McIntyre, 1966; Walder, Cohen, Daston, Hirsch and Leibowitz, 1967; Walder, Cohen and Daston, 1967) have described an extensive and systematic training program for parents aimed at teaching operant principles. Training programs have been developed for parents of children covering the range from "normal" to "deviant", including parents of presumably "normal" children taking adult education classes in child management, and parents of children and adolescents with problems: children in mental hospitals, (Lehrer, Schiff, and Kris, 1972), special classes and schools (Kuhlman, 1970), outpatient clinics (Patterson, 1972), and institutions for the retarded (Galloway and Galloway, 1970). With the current emphasis on short term outpatient services through community mental health centers, there is an increased demand for utilizing nonprofessional resources for treatment. Training

programs for parents have become important elements of outpatient care in several such settings (Liberman, Rivera, Weathers, and Bryan, 1971; Huntsville-Madision County Mental Health Center, 1971).

This paper describes one such group to which parents were referred after only brief screening. Generally this screening consisted of a lenghly questionnaire, an intake interview with a clinician at a mental health center, and perhaps a brief discussion of the case at a disposition conference. Referrals to the program were made for those parents who indicated that their children manifested behavior problems. Although in a few cases the parents were being seen elsewhere in the mental health center, generally this training group was their only therapeutic contact. The group, thus, tested the adequacy of this model for outpatient treatment of children at a mental health center.

METHOD

Setting. The group was run at a large comprehensive commuunity mental health center, operated by the psychiatry department of a recently established medical school. At the start of the group, the mental health center has been in operation only three months. It was a rapidly growing institution, which would eventually have the task of serving ten suburban and urban communities with a population of 235,000, as well as being the primary clinical training site for the psychiatry department and various other departments of an affiliated university. At the beginning of the group, the mental health center's building had

just opened, and the center was not yet fully staffed. The demand for direct clinical services was beginning to be felt, and there was pressure to develop procedures to avoid waiting lists. Also we were feeling the need to provide training both for students and for staff members, most of whom had just been hired. The group was thus structured so as to provide opportunities both for clinical service and for training.

Population. Ten couples and one single (widowed) parent agreed to participate in the course. The group was heterogeneous. Parents came from upper, middle, and lower class backgrounds, although they were predominantly lower middle class. The ages of their children ranged from three to sixteen, and the presenting problems varied from severe brain damage and childhood psychosis to school problems and relatively minor behavioral abberations. Only one of the sets of parents had initially approached the mental health center for behavioral training specifically, and four had been in some form of treatment at the mental health center prior to the course, which, in all cases, continued throughout the duration of the course. All participants were white.

Format. The format of the course was similar to that described by Walder and by Liberman, but with some modifications. The course was for ten two-hour sessions, and met once each week in the evening. The first hour of each session consisted of a didactic discussion of operant principles, and the second hour consisted of a small group meeting, in which a group of two or three sets of parents met with an individual clinician. At the latter session, parents were given progressive homework assignments,

based on the didactic portion. Assignments were based on the progress that parents made during the previous week. They were given help in carrying out interventions after all previous steps of observation and analysis had been accomplished. Previous experience had suggested that instruction in control of their child's deviant behavior was a sufficiently strong reinforcer for parents to motivate them to observe and analyze behavior accurately. The assignments were in order:

1. Choose a behavior to work on.
2. Take, where appropriate, baseline frequency data and/or written accounts of the antecedents and consequences of problem behaviors. Graph, where possible.
3. Apply any intervention, and graph results.
4. Repeat steps 1-4 on another behavior.

Parents were permitted to advance a step only after they had successfully completed the previous step. They were also given weekly reading assignments in Dr. Becker's book, Parents are Teachers. A session by session outline of the course is presented in Table 1.

Staff training. The staff that was being trained included two staff social workers, one staff psychologist, and two graduate students in clinical psychology. All trainees had had some familiarity with behavior therapy, but prior training in the area varied from extensive (in one case) to quite superficial. The trainees sat in on the didactic portion of the workshop, and

led small groups in which homework was discussed. Dr. Gordon and I either sat in on each small group session or discussed it thoroughly afterward with each trainee.

Outcome measures. In addition to the behavioral observations that the parents brought in, we devised several tests of the parents' learning. In the last session, parents were asked to list the five most important things they learned from the group, to describe changes in their child(ren) and general family conditions, and to give criticisms of the course. Also, on the first and last days of the course, parents were given a brief paragraph to read describing the "Case of Billy" (Wahler, 1969) who manifested a number of behavioral problems. Parents were asked to describe how his behavior should be managed. Leaders of the small group also kept records of their clinical observations of the parents.

RESULTS

The indices showing the greatest positive effects of the group were the Case of Billy and the questionnaire.

The Case of Billy. The authors independently and blindly coded the parents' openended answers to "The Case of Billy" for three types of responses: (1) pinpointing of a behavior; (2) specific use of positive reinforcement, and (3) appropriate use of punishment (i.e., use of time out combined with positive reinforcement of alternative behavior). Reliabilities between

pairs of raters for each of the three categories varied between 79% and 96% with a mean of 90%.* Table 2 shows that parents dramatically increased in recommending appropriate behavioral techniques. Interestingly, improvement in performance on the Case of Billy was negatively but nonsignificantly correlated with success in changing behavior, thus indicating that having verbal concepts and ability to act on them were, at best, unrelated.**

Questionnaire. On the questionnaire asking parents what they got from the course, the outcome was more general. The items most f quently mentioned (i.e., by five or more parents) included (1) that reward is preferable to punishment in changing childrens behavior; (2) that punishment, if used, should preferab_/ be in the form of time-out, with prompt positive reinforcement for alternative acceptable behavior; and (3) that extinction is a useful technique to decrease incidents of unacceptable behavior. Ten of the parents who responded to this questionnaire rated their problem child's behavior as having improved while four rated their problem children as having remained the same. Parents also rated their own behavior as generally improved, and that of others in their household either as unchanged or improved. This was not a universal finding, however. Of the 14 parents who filled out the questionnaire, three rated the general emotion

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*Percent Reliability = Agreements ÷ (Agreements + Disagreements)

**In this computation, a family with one or more success in changing behavior was coded as +1, a family without success as -1, and a family with only temporary success as 0. Improvement in the Case of Billy was scored as number of codable responses, pretest - posttest.

atmosphere in their homes as worse, and two rated their spouse's behavior as worse.

Behavior Change. Each of the 10 couples and one single parent in the group identified at least one specific behavioral problem to work on in the course (see Table 3). Two families dropped out of the group, and eight of the nine others carried out at least one program. Seven of these families carried out at least one successful behavioral intervention. Two of these, however, abandoned their programs before gains could be consolidated.

Analysis of Treatment Failures. The treatment failures of this group were particularly interesting in light of the potential use of this procedure as an out-patient therapy modality.

Of the 14 sets of parents, two dropped out. One attended only a single session (the second), and thus was never really exposed to the group. The other couple was in the middle of divorce proceedings. Midway through the group they dropped out, and the mother dropped out of her individual therapy as well. Their telephone was disconnected, and we were unable to reach them.

Of the 12 sets of parents who remained in the course, two never carried out a program. In both of these cases the parents had done an adequate job of pinpointing and recording behavior, but they found themselves unable or unwilling to use positive reinforcement. One was the case of a 13-year-old boy who threw

temper tantrums (predominantly loud cursing around the house) while doing his homework. The boy was an underachiever in school, and his parents were extremely anxious about this, as well as about many other things. For a few days they attempted to carry out an ineffectual program of positive reinforcement (money) for studying without cursing. As this did not have an immediate effect, they abandoned it. It became obvious that the father, despite his attempts to reward his son, was still punishing the boy's academic behavior by his own anxious responses to the boy's failures. The father was unable to change his behavior in this way. The boy's behavior eventually improved only after an outside tutor was hired and the father stopped interacting with his son around the issue of school work. Later, the father referred himself to the mental health center for treatment of his own severe anxiety condition. In the other case, the parents of a three-year-old boy, who was described as constantly whining, were unwilling to use positive reinforcement. On a number of occasions the mother hinted at her never having desired a child, but feeling that it was a "duty". The child seemed not to manifest any behavioral problems outside the home (e.g., in nursery school, in a diagnostic evaluation, etc.) The parents did not use any of the positive reinforcement programs worked out with the staff. They did, however, devise a punishment program of their own, in which they squirted the child with a water gun when he whined. This program was effective in stopping the behavior, although, by our coding scheme, we rated it as a failure since no positive reinforcement was used.

Two families had equivocal results. The parents began programs that worked (both involving positive reinforcement), but abandoned them. In both of these families, the fathers believed in the use of punishment in principle, and used this in marital spats. In both cases there were severe marital problems, and one of the couples split up temporarily during the group, ostensibly over an argument about use of rewards and punishments. Both couples refused offers of marital therapy, but the latter couple expressed the view that this group helped their marriage, because it clarified a number of issues, and made them talk about them.

Staff training. Although previous to the group only two of the trainees had done behavioral treatment with children, all trainees did after the group. Although no quantitative measures were taken of the training programs effectiveness, the trainees all reported increased comfort and expertise in the use of behavioral concepts and techniques, and expressed preference to this form of training over didactic courses and/or individual case supervision.

DISCUSSION

An examination of the factors contributing to the strengths and weaknesses of our parent's behavior modification group may highlight considerations for future efforts. Although the success rate of the participants is lower than the 100% obtained by

Dr. Gordon in an adult education course offered in a local high school, the group was successful in alleviating a substantial number of child behavior problems and in alerting parents to alternative strategies of child management. Recall that 7 of the 11 participating families were able to excute at least one successful behavior intervention with their child.

More instructive, though, in terms of planning future groups is consideration of some of the difficulties. Selection of parents for group participation proved inadequate and handicapped group functioning. For instance, the group was quite heterogenous in all respects, including identified "problem" children ranging in age from pre-school to late adolescence. Moreover, some of the parents had considerable emotional difficulties of their own. While marital problems and individual psychopathology are not necessarily contra-indications for participation in a group of this type, they do detract from adopting a formal didactic approach. Several parents complained about the class-room like procedure employed and, for many, this was clearly inappropriate. Although one parent (a widow) was psychotic and one couple was experiencing severe marital and personal neurotic difficulties, success was realized in ameliorating their children's problems. It should be noted, however, that both cases had been in some form of therapy prior to entering the group, and this treatment continued throughout the group. Generally speaking, parents with personal, emotional difficulties seem to require a more clinical and less didactic approach for lasting gains.

This highlights two issues requiring comment. The guidelines for determining whether individual, family or group therapy is the treatment of choice for clients complaining of management problems with their children has yet to be adequately determined. At times, extra-clinical factors such as demand for immediate clinical services and long waiting lists influence treatment disposition. While group treatment modalities seem to offer both economy and efficiency, they are of questionable value for some clients. And secondly, criteria must be established for determining when and for whom a formal group educational as opposed to a mixed clinical-didactic approach is appropriate treatment. Our own experience suggests that where parents reveal significant personal or marital problems, a formal education approach is insufficient. This emphasizes the need for careful screening prior to group admission.

Finally, success may be enhanced in subsequent groups by a more deliberate attempt to heighten the motivation of the participants. For instance, requiring parents to pay for the entire course at its initiation (cf. Liberman et. al., 1971; Huntsville-Madison County Mental Health Center, 1971) may have increased both the attendance and success rates of the participants. Explicit reinforcement of the parents for their efforts in collecting data and implementing programs should be built into parent's training program.

In conclusion, our results suggest that academically oriented courses in behavior management are not a sufficient treatment for a large percentage of child cases referred to psychiatric treatment facilities, although they may be adequate for other parent populations (i.e., public school parents). Where careful screening reveals marital difficulties and individual psychopathologies, a more clinical group treatment approach should be considered. However, the fact that 77% of our group participants did carry out successful programs and that the parents did tend to learn the principles of behavior modification suggests that formal parent behavior modification courses can be the major treatment offered for certain selected clients, and of considerable adjunctive value with others. They also provide an excellent format for staff training.

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Table 1

Outline of Parent Training Group in Behavior Modifi .tion

Session #1, November 14

1. introduction by group members
2. overview and opening remarks
3. stating problem behaviorally - exercise
4. counting - excercise
5. small groups - decide on one problem as well as way of collecting data
6. reconvene into large group and each set of parents will state their assignment
7. assignment - collect base line data, ready a portion of parent manual (Living with Children or Parents are Teachers)

Session #2, November 21

1. verbal conditioning demonstration
2. film - discussion
3. small groups - graphing baseline data
4. assignment - ready a portion of parent manual, collect more baseline data

Session #3, November 28

1. parents show graphs to group
2. formal presentation of acceleration techniques - reinforcement (types, timing, schedules)
3. presentation of deceleration techniques - extinction, punishment, time-out
4. small groups - develop an intervention program
5. assignment - carry out program and graph results

Group leaders to make telephone contact with their assigned parents during the week.

Session #4, December 5

1. presentation on programming complex behavior
2. parents develop a second program to increase their rate of positive reinforcement of their child
3. small groups - discuss original program and get parents started on counting the positive reinforcement they dispense
4. assignment - continue original program and get baseline of positive reinforcement

Session #5, December 12

1. large group review of all programs
2. small groups - refine original program and establish a self-control program for parents if necessary
3. assignment - continue original program and increase positive reinforcement

Session #6, December 19

1. modeling
2. techniques for reducing avoidance behavior
3. small groups - work on programs

Session #7, January 2

1. general review
2. questions and answers
3. small groups

Session #8, January 9

1. review test - case of Billy
2. small groups - develop a third program with more responsibility being turned over to the parents

Session #9, January 16

1. large group discussion of programs
2. small groups - guide parents with third program

Session #10, January 23

1. review
2. small groups - where to go from here, i.e. future programs, other services needed, etc.

Table 2

Response to Case of Billy*

Technique	Pretest	Posttest
Pinpoint	1	7
Positive Reinforcement	3	8
Punishment	0	3
TOTAL	4	18
Number of Parents who gave at least one response	3	8

*Only parents who attended both the first and last sessions, in which the "Case of Billy" was presented are included in this table. Six of the eleven families and nine of the twenty-one individual parents are represented.

Table 3

Summary of Parents' Behavior Modification Programs

Family	Sex of child	Age	Target behaviors	Programs carried out
1	female	6	tantrums	positive reinforcement & extinction
2	male	6	amt. of time to go to bed	positive reinforcement
			bedwetting	none
	male	9	amt. of time to go to bed	positive reinforcement
3	male	8	cursing	positive reinforcement & extinction
			sleeping in own bed	positive reinforcement
			brushing teeth	positive reinforcement
4[b]	male	6	fear of going to school	none
5	male	10	tantrums	positive reinforcement & time out
	female	13	initiating conversations	positive reinforcement
			school work	positive reinforcement
6	male	3	whining	none
7	male	8	interrupting conversations	positive reinforcement
8[b]	male	12	interrupting conversations	none

Table 3

Summary of Parents' Behavior Modification Programs

f child	Age	Target behaviors	Programs carried out	Results[a]
male	6	tantrums	positive reinforcement & extinction	+
le	6	amt. of time to go to bed	positive reinforcement	±
		bedwetting	none	0
le	9	amt. of time to go to bed	positive reinforcement	±
e	8	cursing	positive reinforcement & extinction	+
		sleeping in own bed	positive reinforcement	+
		brushing teeth	positive reinforcement	+
e	6	fear of going to school	none	0
e	10	tantrums	positive reinforcement & time out	+
ale	13	initiating conversations	positive reinforcement	0
		school work	positive reinforcement	0
e	3	whining	none	0
e	8	interrupting conversations	positive reinforcement	±
	12	interrupting conversations	none	0

Table 3 (Continued)

Family	Sex of child	Age	Target behaviors	Programs carried out
9	male	5	talking in complete sentences	positive reinforcement
			amt. of time to dress in the morning	positive reinforcement
10	male	12	lying	positive reinforcemen
			cursing	
11	male	9	tantrums	positive reinforcemen
			use of proper utensils at meals	positive reinforcemen
			inappropriate sounds at meals	positive reinforcemen & extinction
			amt. of time to dress in morning	positive reinforcemen

[a] + indicates positive results; 0 indicates negative results; ± indicates init but abandonment of program before results could be consolidated.

[b] terminated after only superficial involvement in course

er, Gorden, Leiblum, APA, August, 1973

Table 3 (Continued)

Sex of child	Age	Target behaviors	Programs carried out	Results[a]
male	5	talking in complete sentences	positive reinforcement	+
		amt. of time to dress in the morning	positive reinforcement	+
male	12	lying	positive reinforcement	+
		cursing		
male	9	tantrums	positive reinforcement	+
		use of proper utensils at meals	positive reinforcement	+
		inappropriate sounds at meals	positive reinforcement & extinction	+
		amt. of time to dress in morning	positive reinforcement	+

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